博愛有心人每月捐款計劃表格 Pok Oi Friend Monthly Donation Form

(每月捐款熱線 Hotline: 2479 3300 電郵 Email: pohfriend@pokoi.org.hk)

電話 Tel.: 2479 0022 傳真 Fax: 2479 5025 網址 Website: www.pokoi.org.hk

地址 Address: 新界元朗坳頭博愛醫院賽馬會護理安老院大樓地下高座 UG/F., POH Jockey Club Care & Attention Home Building, Au Tau, Yuen Long

捐款者資料 Donor's Information

*姓名 Name: (先生 Mr. / 女士 Ms.) (Eng) (中文)	
出生日期 Date of Birth: 日 DD 月 MM 年 YYYY	*聯絡電話 Tel. No.:
電郵 Email:	傳真 Fax:
*通訊地址 Postal Address:	
若收據抬頭非捐款者本人，請列明: Please specify the recipient if it is different from the donor:	□為幫助節省行政開支，本人不需收據。 To help save administration costs, please do not send me a receipt

***必需填寫 are required fields**

****若捐款人姓名及地址欠奉，恕未能寄發收據。Pok Oi Hospital regrets that it cannot provide receipts to donors who fail to provide either their name or address.**

*****一年內累積捐款港幣一百元以上可憑收據在香港申請扣減稅項。Accumulated donations of HK$100 annually or above are tax deductible with a receipt in Hong Kong.**

捐款金額 Donation Amount

我願意成為博愛有心人，每月捐贈以下款項: I want to be a Pok Oi Friend and donate the following Monthly sum:

□HK$1,000 □HK$500 □HK$250 □HK$100 □其他金額 Other donation amount HK$________________

捐款方法 Donation Method

□信用卡 Credit Card (信用卡捐款者可郵寄至本院或傳真此表格至 2479 5025。Credit Card donation can be sent to us by mail or by fax to 2479 5025)

□VISA □MasterCard □American Express			
持卡人姓名 Cardholder's Name		信用卡號碼 Card Number	
信用卡簽發銀行 Issuing Bank		有效日期至 Expiry Date	月 MM/ 年 YY
持卡人簽署 Cardholder's Signature	(簽名必須與閣下之信用卡簽名完全相同) (Please ensure that you sign the form in the same way as you sign your credit account.)		

* 本人授權博愛醫院由本人之信用卡戶口轉賬上述指定金額作每月定期捐款。此授權在本人之信用卡有效期過後及獲發新卡後仍繼續生效，直至另行通知。
The authorization for the Pok Oi Hospital to debit the specified amount monthly from his/her credit card account will continue after the expiry date of the credit card and with the issuance of a new card until further notice.

□**銀行每月自動轉賬 Bank Monthly Autopay** (請填妥本表格並將正本郵寄至本院。Please kindly return the original of this from to us)

銀行戶口每月自動轉賬授權書 Bank Monthly Direct Debit Authorization

收款之一方名稱(收款人) Name of party to be credited (the Beneficiary)	銀行編號 Bank no.			分行編號 Branch no.			收款賬戶之號碼 Account no. to be credited								
博愛醫院 **Pok Oi Hospital**	0	2	4	2	2	1	1	6	6	3	3	3	0	0	1

本人(等)現授權下述之銀行(「該銀行」)，根據收款人不時給予該銀行之指示，自本人(等)下述戶口轉賬予收款人。但每次轉賬金額不得超過以下指定之限額。 本人(等)同意該銀行毋須證實該等轉賬是否已通知本人(等)。 如因該等轉賬而令本人(等)之下述戶口出現透支(或令現時之透支增加)。本人(等)會共同及各別承擔全部責任。 本人(等)確證在本授權書內之簽名，與本人(等)下述戶口於該銀行簽署紀錄完全相同。 本人(等)同意如下述戶口並無足夠款項支付有關轉賬，該銀行有權不予辦理且可收取有關之手續費用，該等費用一概由本人(等)支付。 本人(等)同意取銷或更改本授權書之任何通知，須於取銷或更改生效日最少兩個工作天之前交予該銀行。 本授權書將繼續生效直至另行通知為止或直至下列到期日為止(以兩者中最早之日期為準)。
I/We hereby authorize my/our below-named bank (the"Bank") to effect transfer from my/our below-mentioned account to the above-named Beneficiary in accordance with such instructions as the Bank may receive from the Beneficiary from time to time, provided always that the amount of any one such transfer shall not exceed the limit indicated below.
I/We agree that the Bank shall not be obliged to ascertain whether or not notice of any such transfer has been given to me/us.
I/We jointly and severally accept full responsibility for any overdraft (or increase in existing overdraft) on my/our below-mentioned account which may arise as a result of any such transfer(s).
I/We confirm that my/our signature(s) on this authorization is/are the same as filed with the Bank for the operation of my/our below-mentioned account to be debited for the transfer.
I/We agree that should there be insufficient funds in my/our below-mentioned account to meet any transfer hereby authorized, the Bank shall be entitled, at its discretion, not to effect such transfer in which event the Bank may make the usual service charge to be paid by me/us.
I/We agree that any notice of cancellation or variation of this authorization which I/We may give to the Bank shall be given at least two working days prior to the date on which such cancellation or variation is to take effect.
This authorization shall have effect until further notice or until the below given expiry date (which shall first occur).

本人(等)之銀行及分行名稱 My/Our Bank Name and Branch	銀行編號 Bank No.	分行編號 Branch No.	本人(等)之賬戶號碼 My/Our Account No.
本人(等)在結單/存摺上所紀錄之名稱 My/Our Name as record on Statement/Passbook	本人(等)在結單/存摺上所紀錄之地址 My/Our Address as recorded on Statement/Passbook		
每月捐款之限額 Limit for Each	到期日(請參閱附註1) Expiry Date (See Note 1) D D M M Y Y	本人(等)之簽名** My/Our Signature(s)	日期 Date
捐款人之姓名(若非賬戶持有人) Name of Debtor(If other than account holder)	由本機構填寫(支賬參考) For Pok Oi Hospital Use Only (Debtor's Reference)		
以下由銀行填寫 For Bank Use Only	Signature Verified		

****簽名必須與閣下(等)之戶口簽名完全相同。Please ensure that you sign the form the same way that you would sign your bank account.**

附註 Notes:
1)本直接付款授權書將於到期日一欄中所填寫之日期自動撤銷。如欲使本直接付款授權書無限期有效(或直接予以撤銷為止)，即請將該欄留空。但該銀行將不受此限，並可將超過兩年未有任何過賬紀錄之 直接付款授權宣告失效，及可刪除該授權紀錄而毋須另外通知。
2)本人(等)並授權實行可由本人(等)戶口內支取因執行此指示而所需之各項費用，特此聲明。
3) 表格上如有任何塗改，請在旁簽署。

1)This Direct Debit Authorisation will be cancelled automatically on the date included in the box marked "Expiry Date". If you wish the Direct Debit Authorisation to have effect indefinitely (or until cancelled by you), please leave box blank. If there is no transaction being recorded under this direct debit authorization for over two years, the Bank may delete this direct authorization without giving any notice.
2)I/We hereby further authorize you to debit my account with all charges and expenses whatsoever in effecting my/our instruction.
3)Please sign against any alterations you make on this form.

閣下所填寫的個人資料絕對保密，博愛醫院或受其委託服務提供者只用作捐款處理、寄發收據、募捐及其他與本院相關的宣傳事務之用途。若 閣下不願意收到上述資訊及資料，請在方格內加上剔號。□
Your personal data will be kept strictly confidential. Pok Oi Hospital or its service providers will only use the above information for donation administration, receipting, fundraising and/or other promotion matters related to Pok Oi Hospital. If you prefer not to receive such promotion communication materials, please tick here. □